DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085021	A. BUILDING _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCROFT	255 POSSUM PARK ROAD NEWARK, DE 19711

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F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from January 25, 2017 through February 2, 2017. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 83. The Stage 2 survey sample size was 29. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; DON - Director of Nursing; EMR - Electronic Medical Record; FMD - Facility Maintenance Director; LPN - Licensed Practical Nurse; MDS - Minimum Data Set/assessment tool used in long term care; NHA - Nursing Home Administrator; RN - Registered Nurse; SW - Social Worker; Blanchable - defined area of redness that becomes pale under applied light pressure; cm / centimeter - measurement of length, width and depth; coccyx - tailbone; Exudate - any fluid that filters from the circulatory system into lesions or areas of inflammation; can be a pus-like or clear fluid; MediHoney - medical-grade honey products for the management of wounds and burns; Non-blanchable - defined area of redness that does not become pale under applied light pressure; Pressure ulcer/PU- sore area of skin that develops when the blood supply to it is cut off due to pressure;	F 000	F253 1. A. No residents were adversely affected by this practice. Scrapes on bathroom doors in Rooms 216, 221, 224 and 227 were sanded and painted. B. All residents have the potential to be affected by this practice. The Facility Maintenance director/designee will inspect all bathroom doors. Any identified scrapes will be sanded and painted by the maintenance staff. C. A root cause analysis was conducted to identify any system/policy changes are needed. An entry on the environmental rounds checklist will be added to include inspection of the bathroom doors for scrapes and any identified scrapes will be sanded and painted. The ED/ designee will in-service maintenance staff on the new item listed on the environmental checklist. D. The ED/designee will audit 10 random bathrooms for scrapes weekly x 4 weeks until 100%, then monthly X 2 months until 100% results will be reviewed and discussed at QAPI for recommendations for the need for further monitoring. 2. A. No resident was adversely affected by this practice. The loose call bell in Room 234's bathroom has been secured by the maintenance staff. B. All residents have the potential to be affected by this practice. The Facility Maintenance Director/designee will inspect all bathroom call lights to ensure that they are securely fastened to the walls. C. A root cause analysis was conducted to identify any system/policy changes are needed. An entry on the environmental rounds checklist will be added to include inspection of the bathroom call light to ensure that they are securely fastened to the wall. The ED/designee will in-service maintenance staff on the new item listed on the environmental checklist. D. The ED/designee will audit 10 bathroom call lights to ensure they are securely fastened to the wall weekly X 4 weeks until 100%, then monthly X 2 months until 100%. Results will be reviewed and discussed at QAPI for recommendations for the need for further monitoring.	4/10/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joyce Winters, NHA — TITLE: Executive Director — (X6) DATE: 2/24/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Sacral /sacrum - large triangular bone at the base of the spine; Slough - yellow, tan, gray, green or brown dead tissue; Stages of pressure ulcers (categorization system used to describe the severity of PUs): - Stage I (1) - a reddened area of intact skin usually over a boney prominence, that when pressed does not turn white. This is a sign that a PU is starting to develop; - Stage II (2) - skin blisters or skin forms an open sore. The area around the sore may be red and irritated; - Stage III (3) - skin develops an open, sunken hole called a crater. There is damage to the tissue below the skin; - Stage IV (4) - ulcer has become so deep that there is damage to the muscle and bone and sometimes to tendons and joints; - Unstageable - Tissue loss in which actual depth of the ulcer is unable to be determined due to the presence of slough and/or eschar (dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound bed); - Deep Tissue Injury (DTI) - Purple or maroon localized area of discolored intact skin. May be preceded by tissue that is painful, mushy, firm, boggy (wet, spongy feeling), warmer or cooler than adjacent tissue; Dermis-the thick layer of living tissue below the epidermis that forms the true skin.	F 000	B. A. root cause analysis was conducted to identify any need for changes in systems/policies. All residents who trigger for wounds will be reviewed by the IDT at weekly at risk meeting for complete and accurate weekly assessments and documentation by Unit Manager/Wound Team. Unit Manager/Wound Team will be in-serviced by Staff D/Designee on comprehensive and accurate wound/skin assessments and accurate documentation. 4. A. DON/Designee will audit all new admissions and current residents with wounds for thorough, accurate/ complete assessments, and documentation on EMR weekly until 100% compliance times 4 weeks, then monthly until 100% compliance times 2 months. The DON/Designee will report to the QAPI committee for review and recommendations to achieve sustained compliance. B. DON/Designee will audit weekly skin assessments and daily skilled documentation for accuracy and completeness weekly until 100% compliance times 4 weeks, then monthly unit 100% compliance times 2 months. The DON/Designee will report to the QAPI committee for further recommendations to achieve sustained compliance.	4/10/17
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced	F 253		

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F 253	Continued From page 2 by: Based on observations and interviews, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior for 5 rooms (216, 220, 221, 224, and 234) out of 33 rooms surveyed. Findings include: On 1/25/17 and 1/26/17 during the Stage 1 review and during the environmental tour on 1/27/17 between 1:30 PM and 2:00 PM, the following were observed: Room 216 - There were scrapes on the bathroom door; Room 221 - There were scrapes on the bathroom door; Room 224 - There were scrapes on the bathroom door; Room 227 - There were scrapes on the bathroom door; Room 234 - The call bell in the bathroom was loose from the wall. All findings were reviewed and confirmed with E4 (FMD) on 1/27/17 at approximately 2:00 PM. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference on 2/2/17 at approximately 5:30 PM.	F 253		
F 280 SS=D	483.10(c)(2)(i-li,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

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F 280	Continued From page 3 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care.	F 280	F280 1. R133 continues to reside in the community and is stable. Care plan meeting was scheduled by SW for 2/21/2017 with POA and current plan of care was reviewed to ensure resident's care needs are being met. 2. All Residents have a potential to be affected by this practice. Care plan meeting audit will be conducted/ completed by the Social Worker for new admissions and current residents to ensure residents and family have been offered the opportunity to participate and make decisions on plan of care that meets their needs. 3. A root cause analysis was conducted to identify any need for system/policy changes. The Social Worker will document in the EMR the resident/family member invitation to the care plan meeting. Social Worker/ designee will be in-serviced by NHA/Designee regarding scheduling and documentation of care plan meetings with family/residents after admission to community, quarterly, and as needed to ensure appropriate participation, review, and revision of resident's plan of care. 4. Weekly care plan meeting audit will be completed by DON/Designee for new residents and long term care residents to ensure that all residents that are due for care plan meeting are scheduled or completed. Resident and family invitation and participation will be documented on residents EMR. Review will be done weekly until 100% compliance times 3 weeks, then monthly until 100% times 3 months. Findings of the audits will be submitted to QAPI Committee for review and recommendations to achieve sustained compliance.	4/10/17

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F 280	Continued From page 4	F 280		

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(I) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

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F 280	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on staff and family interviews and record review, it was determined that the facility failed to ensure for one (R133) out of 29 Stage 2 sampled residents that the resident and/or interested family member were included in the care planning process. The clinical record lacked documented evidence that care plan meetings were held and lacked evidence that R133 and/or an interested family member were invited to participate. Findings include: Review of R133's clinical record revealed: R133 was admitted to the facility on 10/1/16. According to both the 10/7/16 admission MDS assessment and the 1/7/17 quarterly MDS assessment, R133 was independent for daily decision making skills. During an interview on 1/26/17 at 12:46 PM, F1 (R133's family member) stated that she was not included in decisions about R133's medicine, therapy or other treatments. F1 stated she is called when there are changes to medications or any other problems, but is not included in any discussion before changes were made. When F1 was asked if she has attended any care plan meetings, she stated that she has heard of the meetings, but has never been invited to one. On 1/31/16 at 3:43 PM during an interview, E3 (ADON) stated that for regularly scheduled (quarterly) care plan meetings, E5 (SW) calls and contacts the family regarding the meetings and that the notes would be in the social services section of the clinical record.	F 280		

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F 280	Continued From page 6 R133's hard copy clinical record and EMR were reviewed on 2/1/17 at 9:13 AM. Both records lacked evidence of any care plan meetings. During an interview on 2/1/17 at 2:49 PM, E5 stated that he contacts family members and/or residents regarding upcoming care plan meetings. E5 stated the meeting was documented on the form titled "Plan of Care Conference Summary," which should be in the hard copy chart. This surveyor informed him that she/he was unable to locate any documentation regarding any care plan meetings. E5 stated he would review the chart. During an interview on 2/2/17 at 8:23 AM, E2 (DON) stated that E5 spoke with him and was unable to locate any documentation of care plan meetings for R133. E2 confirmed there was no evidence that R133's care plan meetings were completed and that family was invited. The facility failed to afford R133 and/or an interested family member the right to participate in care planning nor were they consulted about care and treatment prior to making changes. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference on 2/2/17 at approximately 5:30 PM.	F 280		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 314		

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F 314	Continued From page 7 (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, interviews and review of other documentation as indicated, it was determined that for two (R101 and R180) out of 29 Stage 2 sampled residents, the facility failed to ensure that a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice. For R101, the facility failed to complete a comprehensive assessment of a pressure ulcer (PU) present on admission and failed to accurately complete weekly skin checks. For R180, the facility failed to complete a comprehensive assessment of R180's three PUs upon admission and failed to accurately reassess the 3 PUs during weekly wound evaluations on 1/3/17 and 1/10/17. Findings include: The International NPUAP/EPUAP (National Pressure Ulcer Advisory Panel/European Pressure Ulcer Advisory Panel) Clinical Practice Guideline, second edition published 2014, stated: "...Pressure Ulcer Assessment 1. Assess the pressure ulcer initially and re-assess it at least weekly...1.1. Document the results of all wound assessments...3. Assess and document physical	F 314	F314 1. A. R101 no longer resides in the community. B. R180 no longer resides in the community. 2. A. Residents with pressure ulcers admitted to or currently in the facility have a potential to be affected by this practice. The DON/Designee will review/audit all current wounds for comprehensive assessments to identify any inaccuracies and those inaccuracies will be corrected. B. All residents have the potential to be affected by this practice. The DON/designee will audit all current residents' with pressure ulcers' weekly wound assessment to ensure accuracy. Any identified inaccuracies will be corrected. 3. A. A root cause analysis was conducted to identify any need for changes in systems/policies. All residents admitted with or develop pressure will have their comprehensive skin assessment reviewed at morning clinical meeting to identify issues that need to be re-assessed and/or corrected. The DON/designee will in-service licensed nursing staff on staging pressure ulcers and documentation in the EMR. B. A root cause analysis was conducted to identify any need for changes in systems/policies. All residents who trigger for wounds will be reviewed by the IDT at weekly at risk meeting for complete and accurate weekly assessments and documentation by Unit Manager/Wound Team. Unit Manager/Wound Team will be in-serviced by Staff D/Designee on comprehensive and accurate wound/skin assessments and accurate documentation. 4. A. DON/Designee will audit all new admissions and current residents with wounds for thorough, accurate/ complete assessments, and documentation on EMR weekly until 100% compliance times 4 weeks, then monthly until 100% compliance times 2 months. The DON/Designee will report to the QAPI committee for review and recommendations to achieve sustained compliance.	4/10/17

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F 314	Continued From page 8 characteristics including: location, Category/Stage, size, tissue type(s), color...exudate, and odor...". 1. Review of R101's clinical records revealed the following: R101 was admitted to the facility on 12/13/16. 12/13/16 11:51 PM - The Nursing Admission/Readmission Skin Review stated "...small blister on top of sacrum - not open, white area but skin intact...". 12/13/16 - An Initial Wound Evaluation was not found for the sacral PU. The facility failed to complete a comprehensive assessment of R101's PU on admission. 12/14/16 12:37 AM - An Admission Progress Note stated "...white blister are (sic) on top of sacrum was noted during skin assessment...". 12/14/16 3:40 PM - A Nursing Admission/Readmission Skin review stated R101's skin was intact and no PUs were identified. The document states "...Sacrum redden (sic) area with new preventative treatment...". The facility failed to identify if the sacral reddened area was blanchable or non blanchable, nor does it identify a blister. 12/14/16 11:37 PM - A Nursing Daily Skilled Evaluation stated "...blister to top of sacrum...". 12/15/16 11:03 AM - A nutrition assessment was completed and does not identify R101 as having any PU.	F 314	4 B. DON/Designee will audit weekly skin assessments and daily skilled documentation for accuracy and completeness weekly until 100% compliance times 4 weeks, then monthly unit 100% compliance times 2 months. The DON/Designee will report to the QAPI committee for further recommendations to achieve sustained compliance.	4/10/17

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F 314	Continued From page 9 12/16/16 5:24 PM - A Health Status Note stated, "The coccyx area noted on admission has opened. New order to cleanse...". Again there was no comprehensive assessment completed of the sacral PU. 12/17/16 3:38 PM - A Daily Wound Evaluation described as "Wound #1" stated R101's sacral wound dressing was changed, there was no pain or drainage and the surrounding skin was normal. 12/19/16 11:48 PM - A Weekly Skin Check stated skin is intact and there is blanchable redness to the top of the sacrum, despite the fact that treatments were ongoing. 12/20/16 10:44 AM - A Weekly Wound Progress Evaluation identified R101 as being admitted with a Stage III PU on the coccyx, measuring 0.4 cm by 0.3 cm by 0.1 cm (length x width x depth). The PU wound bed was described as beefy red and yellow with no drainage. The comments section stated to treat with MediHoney and foam dressing daily and as needed. This evaluation was the first time the facility completed a comprehensive assessment of R101's PU, seven (7) days after admission. 12/27/16 10:45 AM - A Nursing Weekly Wound Progress Evaluation stated the PU on the coccyx was resolved. The facility failed to complete a thorough pressure ulcer assessment when they failed to completely describe and stage R101's PU on admission. R101's sacral PU was not staged until seven (7) days after admission. On 1/30/17 at approximately 4:30 PM, during an	F 314		

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F 314	Continued From page 10 Interview with E3 (ADON) and E2 (DON), E3 reviewed R101's clinical record with this surveyor. E3 stated that when a PU was identified on admission, an Initial Wound Evaluation was also to be completed. E3 stated that the LPNs do not complete the staging of PUs, but are expected to fully describe it and measure it. E3 stated there was always an RN supervisor on duty on all three (3) shifts who should complete the initial wound assessment with the LPN. E3 confirmed that a comprehensive assessment was not completed and stated she believed that the 12/20/16 weekly wound assessment was inaccurate when it was staged as a Stage III (3). Findings were reveiwed with E1 (NHA), E2 and E3 during the exit conference on 2/2/17 at approximately 5:30 PM. 2. Review of R180's clinical record revealed the following: 12/30/16 on 3-11 PM shift - R180 was admitted to the facility for rehabilitation. Undated and untimed - A hard copy facility form entitled Admission/Readmission Skin Review revealed a body diagram with the sacral area circled and the following 3 PUs identified within the circled area: (1) Stage II, (2) blue black area identified as a DTI and (3) red, nonblanchable identified as a Stage I. On the bottom of the form, it listed "...Specific Skin Concerns (indicate all that are present...2. Redness (Nonblanche)*...13. Pressure Ulcer*..."If ANY areas are marked with an (*), the nurse must complete the required Initial Wound Review Form". Although the pressure ulcer was not checked in the Specific Skin Concerns section, three (3) PUs were	F 314		

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MILLCROFT	255 POSSUM PARK ROAD NEWARK, DE 19711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 11 identified on the body diagram. The facility lacked evidence that an initial Wound Review Form was completed. The facility failed to complete a comprehensive assessment of R180's 3 PUs identified upon admission, which included measurements. 12/31/16 at 12:48 AM - An electronic facility form entitled Nursing Admission/Readmission Skin Review stated that R180 had a specific skin concern on the sacrum and described it as: "Blue - black region on left buttock. The area is embedded in an area of partial thickness loss of dermis presenting as an open ulcer with a red-pink wound bed without slough. The surrounding skin is intact with non-blanchable redness." 12/31/16 at 1:55 AM - A nurse's note stated that R180 had PUs on the sacrum. 12/31/16 at 3:57 PM - A second electronic Nursing Admission/Readmission Skin Review stated that R180 had a Stage II PU on his sacrum. 1/3/17 at 10:44 AM - Four (4) days later, a Nursing Weekly Wound Progress Evaluation stated that R180 was admitted with a suspected DTI PU on his sacrum, measuring 6 cm x 4 cm, yellow slough covering most of the wound bed and purple in areas. It was unclear why the facility was staging the sacral area as a suspected DTI when there was an open area with yellow slough. 1/10/17 at 10:56 AM - A Nursing Weekly Wound Progress Evaluation noted improvement in R180's sacral PU identified as a suspected DTI, measuring 3.5 cm x 1.2 cm with the open area	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085021	A. BUILDING _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCROFT	255 POSSUM PARK ROAD NEWARK, DE 19711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 12 covered by slough and the purple area resolved. It was unclear why the facility continued to stage the open area covered by slough as a suspected DTI. 1/24/17 at 10:45 AM - A Nursing Weekly Wound Progress Evaluation noted further improvement with R180's sacral PU now identified as unstageable, measuring 1 cm x 0.2 cm. 1/30/17 at 4:28 PM - During an interview with E2 (DON) and E3 (ADON), findings were reviewed and confirmed as the facility failed to complete a comprehensive assessment of R180's three PUs upon admission and failed to accurately reassess the 3 PUs during the weekly wound evaluations on 1/3/17 and 1/10/17. 1/31/17 at 10:43 AM - An observation of R180's sacral wound during wound rounds with E3 (ADON), E6 (Unit Manager, RN) and E7 (Wound Care Consultant) revealed that R180's sacral wound was resolved. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference on 2/2/17 at 5:30 PM.	F 314		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Millcroft **DATE SURVEY COMPLETED: February 02, 2017**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual survey was conducted at this facility from January 25, 2017 through February 2, 2017. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 83. The Stage 2 survey sample size was 29	Cross Refer Cross refer to the CMS 2567-L survey completed January 07, 2017: F253, F280, and F314.	
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer Cross refer to the CMS 2567-L survey completed January 07, 2017: F253, F280, F314.		

Provider's Signature Joyce Winters, NHA Title Executive Director Date 2/24/17